Referral for At Risk Children's Program Funding

Preliminary Assessment and Determination Of At-Risk Status

Date of Referral_____County_____

School_____ Area Mental Health Program_____

Child/Adolescent_____

Date of Birth_____ SSN_____

Parent or Guardian
Name_____

Parent or Guardian
Address _____

Phone Number: Home_____ Work _____

Referring Person/Agency:_____

Phone_____

1. Is the child/adolescent currently placed outside of his or her home?
   Yes No If Yes, where and when admitted?

2. If the answer to item number 1 is No, then, is the child/adolescent currently at risk of institutionalization or other out-of-home placement? Yes No
   Explanation:

3. Please list the out of home placements for this child/adolescent. Include the dates and length of stay.

4. Identify agency personnel/community supports currently involved with the child:

Social Services	Contact Name Phone Number_____
School System	Contact Name Phone Number_____
Juvenile Court/Probation	Contact Name Phone Number_____
Mental Health	Contact Name Phone Number_____
Health Care	Contact Name Phone Number_____
Other	Contact Name Phone Number_____

5. What is the DSM IV Diagnosis? (if known/established)

Axis I_____

Axis II_____

Axis III_____

Axis !V_____

Axis V _____

6. Is the child currently in an exceptional children's program at school or receiving any special services in school? If so, what is the area of exceptionality?

7. What effect has the child's or adolescent's emotional or behavioral problems (or both) had on the following settings?

Home: (Briefly describe the effect)

School: (Briefly describe the effect)

Community/Legal: (Briefly describe the effect)

8. What are the strengths and barriers to family involvement?

   Strengths: (i.e., active participation in the child's life, has transportation, support from community)

   Barriers: (i.e., Transportation, health issues, work schedule)

9. What does the child's family identify as the most important goals/needs at the present time?

10. From your perspective, please describe what you think are the child's/adolescent's and family's goals/needs?

_____ _____

Signature of Referral Source Date

When you have completed this form, please fax, mail, or take this form and your screening assessment to:

For Area Mental Health Program Use Only

Date of CAFAS Evaluation_____

Total Score _____
Role Performance_____
Behavior toward Self/Others_____
Moods/Self Harm _____
Substance Use_____
Thinking _____

Date of AOI Part I _____

Total Protective_____
Total Risk_____

☐ Meets criteria for At-Risk-Children's Program

Effective Date: _____

Record Number: _____

Assigned Case Manager: _____

☐ Does not meet criteria for At-Risk Children's Program

Present for Eligibility Determination:

_____

Parent/Guardian Signature

_____

Referral Source Signature

_____

Area Program Representative Signature

_____

Other Signature/Title/Relationship to Child